TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LANDON BAIRD DDS

Respondent Name
CITY OF WICHITA FALLS

MFDR Tracking Number
M4-16-1140-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider this claim it was not paid at the submitted fees. You approval states approved with no reduced fee amount listed. Very misleading. We are owed $814.00. Please pay immediately."

Amount in Dispute: $830.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement has been made at the TDI-DWC dental fee schedule as outlined in rule 134.303."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2015 and October 26, 2015	D0140 and D2740 x 2	$830.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.303 sets out the 2005 Dental Fee Guideline.
3. 28 Texas Administrative Code §134.1 sets out the Medical Reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B13 – Previously paid. Payment for this claim/svc may have been provided in a prev payment.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P12 – Per TDI-DWC rule 134.303 Dental Fee Guideline, the maximum reimbursements are based on the Texas Medicaid Dental Fee Schedule multiplied by 200%.
   - B13 – Duplicate charge(s). Previously audited and recommended for payment at fee schedule.

Issues

1. Did the insurance carrier issue payment for the disputed dental services?
2. Is the requestor entitled to additional reimbursement for the dental services?

Findings

1. The requestor seeks resolution of dental services rendered on October 12, 2015 and October 26, 2015, denied/reduced by the insurance carrier with denial reason code "B13 – Previously paid. Payment for this claim/svc may have been provided in a prev payment, P12 – Workers' compensation jurisdictional fee schedule adjustment, P12 – Per TDI-DWC rule 134.303 Dental Fee Guideline, the maximum reimbursements are based on the Texas Medicaid Dental Fee Schedule multiplied by 200% and Duplicate charge(s). Previously audited and recommended for payment at fee schedule."

   Review of the submitted documentation supports that the insurance carrier issued a payment as follows:

Date of Service	Dental Code	Billed Amount	Dental Fee Schedule	Insurance Carrier Payment(s)	Amount Due
10/12/15	D0140	$55.00	$38.32	$38.32	$0.00
10/26/15	D2740	$935.00	$528.00	$528.00	$0.00
10/26/15	D2740	$935.00	$528.00	$528.00	$0.00

   Reimbursement is determined per 28 Texas Administrative Code §134.303, applicable to professional dental services provided on or after June 15, 2005. The disputed services were reduced with denial reason code "P12 – Per TDI-DWC rule 134.303 Dental Fee Guideline, the maximum reimbursements are based on the Texas Medicaid Dental Fee Schedule multiplied by 200%."

   28 Texas Administrative Code §134.303 (b) states, "For coding, billing, reporting, and reimbursement of dental treatments and services, Texas Workers' Compensation system participants shall apply the Texas Medicaid Dental Fee Schedule in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.303 (c) states, "To determine the maximum allowable reimbursements (MARs), the following apply: (1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%. (2) For products and services for which the Texas Medicaid Dental Fee Schedule does not establish a value, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   28 Texas Administrative Code §134.303 (c) (e) states, "In all cases, reimbursement shall be the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge; or (3) workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

   Review of the ADA Dental Claim Form, box 38 identifies the place of treatment as 11 to indicate that the services were rendered in an office. The MAR amount for dental services provided in a non-facility setting is as follows:

   - The Texas Medicaid Dental Fee Schedule for dental code D0140, tooth system JP, is $19.16 x 200% = MAR $38.32. The requestor seeks $55.00 the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge is the MAR amount. As a result, the requestor is entitled to reimbursement in the amount of $38.32. The insurance carrier issued payment in the amount of $38.32, therefore no additional reimbursement is recommended for dental code D0140.
   - The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth system JP, tooth number 8 is $264 x 200% = MAR $528.00. The requestor seeks $925.00 the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge is the MAR amount. As a result, the requestor is entitled to reimbursement in the amount of $528.00. The insurance carrier issued payment in the amount of $528.00, therefore no additional reimbursement is recommended for dental code D6240.
   - The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth system JP, tooth number 9 is $264 x 200% = MAR $528.00. The requestor seeks $925.00 the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge is the MAR amount. As a result, the requestor is entitled to reimbursement in the amount of $528.00. The insurance carrier issued payment in the amount of $528.00, therefore no additional reimbursement is recommended for dental code D6240.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.